Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS661HOS	A. BUILDING _____ B. WING _____	12/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH	6161 WEST CHARLESTON BLVD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure complaint survey conducted in your facility on 12/16/08 through 12/19/08. The survey was conducted using the authority of NAC 449, Hospitals, last adopted by the State Board of Health on August 04, 2004. Complaint # 20326 Substantiated with deficiencies (S320) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	S 000		
S 320 SS=J	NAC 449.3628 Protection of Patient 1. A governing body shall develop and carry out policies and procedures that prevent and prohibit: (a) Verbal, sexual, physical and mental abuse of patients This Regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent an alleged sexual abuse of Patient #1 by Patient #2. Findings include: Patient #1	S 320		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 320	Continued From page 1 The progress notes revealed that Patient #1, a 45 year old female, was admitted to the facility on 11/11/08 per legal 2000, with diagnoses including psychosis new onset, history of hallucinations, asthma, and seizures. Patient #1 was admitted to the observational unit and placed on 15 minute checks for safety. The progress notes indicated that Patient #1 was alert and oriented and interacted with peers. On 11/13/08, Patient #1 was transferred to unit G3B, which was a coed acute psychiatric unit, for further management and evaluation with 15 minute checks. On 11/14/08, the progress notes indicated no behavioral problems were noted, "patient alert and oriented x3." Patient #2 Patient #2, a 33 year old male, was admitted to unit G3B of the facility on 9/29/08, with a diagnoses of bipolar and antisocial personality disorder. The progress notes throughout Patient #2's stay revealed he had many incidents in which he was aggressive and threatening to staff and peers. He refused his medications many times while at the facility. On 10/6/08, the progress notes revealed a psychology consult stating, "In short, this pt is a violence risk and care should be exercised in dealing with him. He is not amendable to behavioral interventions and will likely become agitated in reaction to any denial of what he feels he is entitled to." There were many instances in the progress notes which revealed Patient #2 had been verbally	S 320		

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S 320	Continued From page 2 abusive to female patients. On 10/19/08, an incident was documented in the progress notes in which Patient #2 threw a cup of orange juice at another female patient because she would not talk to him. A self reported incident was investigated regarding an alleged rape that occurred on 11/14/08, at approximately 5:40pm. The facility's incident report dated 11/18/08, indicated a mental health technician (MHT) observed Patient #2 leaving Patient #1's room at 5:40pm, while conducting 15 minute checks on the patients. The MHT went in Patient #1's room and found the patient sitting on her bed. Patient #1 then told the MHT that she had just been raped by Patient #2, who had just walked out. The progress notes dated on 11/14/08, Patient #1 alleged Patient #2 entered the room got on top of Patient #1. Patient #1 told Patient #2, that they could not have sex in the hospital and told him "no", but Patient #1 proceeded to penetrate her vagina with his penis and ejaculated. Patient #2 denied any sexual intercourse after being interviewed immediately after the incident. The progress notes later document that Patient #2 did admit that he had sexual intercourse with Patient #1, however that it was consensual. The nursing staff was notified on 11/14/08 and started their investigation, which included notifying the metropolitan police department whom arrived at the facility around 9pm. Patient #1 and Patient #2 were separated, Patient #1 was placed on close observation and Patient #2 was on full view/constant line of sight after the incident.	S 320		

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S 320	Continued From page 3 According to the director of nursing (DON), the police arrived and interviewed Patient #1 and Patient #2 on the night of the incident. After being interviewed by the police, Patient #1 was transferred to an acute care hospital at 11:30 pm to have a rape kit conducted. Patient #1 returned to the facility from the acute care hospital on 11/15/08 at 6:07am and was transferred to unit E2B, separate from Patient #2. Patient #2 was supposed to have been discharged from the facility prior to the incident, however the discharge was cancelled and he remained in unit G3B under close supervision until he was discharged to his family's home on 11/18/08. The police investigation and rape kit report was not available at the time of the complaint survey and was still under investigation. The acute care facility emergency department history of Present Illness for Patient #1 stated, "She admits that she likes the suspect by the name of...He told her to go to her room, she complied. He soon followed her in her room. She admits they started kissing. She consented to the kissing. He got on top of her and vaginally penetrated her. She states 'he forced himself on me.' He did not wear a condom. He ejaculated inside her vagina and wiped himself off with a towel." According to the DON, patients were placed on either 15 or 30 minute checks. This was where staff will observe a patient at every 15 or 30 minutes depending on the order by the physician. When the staff checked on a patient they documented and coded what the patient was doing or where the patient was at the time of the	S 320		

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S 320	Continued From page 4 15 or 30 minute observation check. The observations were documented on the observation check form for 15 minute checks and 30 minute observations were documented on the unit monitor board form. She further indicated that even though unit G3B is a coed unit, no patients were to enter other patients' rooms at any time per policy. Patient #1 was ordered for 15 minute checks at the time of the incident. The observation check form for unit G3B dated 11/14/08, revealed that Patient 1 was in the dayroom at 5:30pm and in her room at 5:45pm. At the time of the incident Patient #2 was ordered on 11/6/08, for 30 minute checks. The monitor board indicated he was in the dayroom at 5:30pm. An interview with the MHT who had witnessed Patient #2 walking out of Patient 1's room on 11/14/08, after the alleged rape, revealed at the time of the incident there were two people on the unit, he and a nurse. While the MHT was conducting 15 minute checks of the patients, he observed Patient #2 leave Patient #1's room. The MHT stated that at the time of the incident there was no one doing observations in the day area. The nurse was at the nurses station and the MHT was conducting the 15 minute checks. Patient #1's room was at the far corner of the unit, which was not visible from the nurses station. According to the census of the unit at the time of the incident, there were 18 patients on 11/14/08. The DON indicated on 12/16/08, the staffing ratio of patients to staff is 5 to 1 per facility policy. She further indicated that even though unit G3B was a coed unit, no patients were to enter other	S 320		

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S 320	Continued From page 5 patients' rooms at any time per policy. At 5:30pm, 8 patients went to group therapy along with two staff. Nine patients and two staff stayed on the unit including Patient #1 and Patient #2. The DON had indicated that an MHT would sit in the day room area to observe the patients in the unit. However, she indicated that there was no policy that a staff member will sit in the day room area of the units and monitor patients at all times. She further indicated that there could be no one sitting in the day room area monitoring the patients if that staff member was doing 15 or 30 minute checks on the patients. Based on interview with the MHT on duty during the incident no one was sitting in the middle of the unit observing the patients as he was doing 15 minute checks and the nurse was at the nurses station. The staff did not observe Patient #2 enter Patient #1's room between 5:30pm and 5:45pm on 11/14/08. Even though two staff were on the unit for the 9 patients, the current policy and procedures for supervising patients failed to prevent an incident where Patient #2 entered Patient #1's room and allegedly raped her. Severity: 4 Scope: 1	S 320		